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# Report on the implementation of the decisions and recommendations of the Programme Coordinating Board of the Joint United Nations Programme on HIV/AIDS

*Summary*

As per discussions at the Executive Board's second regular session 2010, the present report focuses on selected results of UNDP and UNFPA in addressing HIV and provides an update on the decisions and recommendationsrelevant to UNFPA and UNDP from the 27th and 28thmeetings of the Programme Coordinating Board of the Joint United Nations Programme on HIV/AIDS held in December 2010 and June 2011, respectively.

Elements for a decision are contained in the present report.

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List of acronyms

| | |
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| APNSW | Asia Pacific Network of Sex Workers |
| ASRH | Adolescent sexual and reproductive health |
| CCO | Committee of Cosponsoring Organizations |
| CEWG | Cosponsor Evaluation Working Group |
| DPKO | Department of Peacekeeping Operations |
| EAC | East African Community |
| EIAs | Environmental impact assessments |
| GBV | Gender-based violence |
| GIZ | German Agency for International Cooperation (previously known as the German Agency for Technical Cooperation, GTZ) |
| HCT | HIV Counselling and Testing Campaign |
| MDG | Millennium Development Goal |
| MERG | Monitoring and Evaluation Reference Group |
| MSM | Men having sex with men |
| PCB | Programme Coordinating Board |
| PMTCT | Prevention of mother-to-child transmission |
| PRSPs | Poverty Reduction Strategy Papers |
| SADC | Southern African Development Community |
| SIE | Second independent evaluation |
| SRH | Sexual and reproductive health |
| TRIPS | Trade-Related Aspects of Intellectual Property Rights |
| UBRAF | Unified budget, resultsand accountability framework |
| UBW | Unified budget and workplan |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| YWCA | Young Women's Christian Association |

## I. Context

1. Thirty years into the HIV epidemic, the global AIDS response stands at a crossroads. Important progress has been made in the fight against AIDS since the 2001 and 2006 United Nations General Assembly special sessions — particularly in terms of greater resources, stronger national policy frameworks, wider access to treatment and prevention services and broad consensus on the principles of effective country-level action. The review of major trends also highlights key opportunities, including improved tools to measure HIV incidence, superior strategic information, and momentum in the development of new strategies for HIV prevention, treatment, care and support. At the same time, a review of longer-term political and economic trends points towards flattening resources, fragmented and generic responses, severe gaps in treatment access, weak systemsand perpetuation of social injustices.

2. At the United Nations General Assembly high-level meeting on AIDS in June 2011, Member States adopted a new *Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS*, which sets bold new targets in responding to HIV. This declaration sets the agenda for the future of the AIDS response and provides a roadmap for ending the epidemic. The adoption of a new Security Council resolution on AIDS,i.e., resolution 1983 (2011), which addresses the link between violence against women and HIV in conflict and post-conflict settings, is another significant step in ensuring social stability and national security which could be jeopardized by the AIDS epidemic.

3. In June 2003, the Executive Boards of UNDP/UNFPA, the United Nations Children's Fund (UNICEF) and the World Food Programme (WFP) held a joint meeting to address the recommendations of the first five-year evaluation of UNAIDS, contained in document UNAIDS/PCB(13)/02.2. The joint meeting discussed the implications of the evaluation recommendations for UNDP, UNFPA, UNICEF and WFP, and addressed UNAIDS operational and governance issues. As a result, members of the Executive Boards agreed that a regular item should be placed on the agendas of the Executive Boards concerning follow-up to the decisions and recommendations of theProgramme Coordinating Board (PCB)of the Joint United Nations Programme on HIV/AIDS (UNAIDS).

4. The present report, prepared jointly by UNDP and UNFPA, provides an overview of results achieved in addressing HIV. It also provides an update on the decisions and recommendations from the 27th and 28th PCB meetings, held in December 2010 and June 2011, respectively. Key issues addressed during those meetings that were of particular relevance to UNDP and UNFPA included:the UNAIDS strategy 2011-2015; the UNAIDS unified budget, resultsand accountability framework (UBRAF); and progress on the implementation of the second independent evaluation (SIE).

## II. UNDP and UNFPA results

5. The 27th meeting of the PCB officially adopted the new *UNAIDS 2011-2015 Strategy: Getting to Zero*, which presents a transformative agenda for the global response. The three new strategic directions for UNAIDS are: (a) revolutionizing HIV prevention; (b) catalysing the next phase of treatment, care and support; and (c) advancing human rights and gender equality. Each of these strategic directions is critical, and all are interdependent. Ten medium-term goals[1] towards the long-term UNAIDS vision have been established. Evolved from the priority areas of the UNAIDS outcome framework, these goals aim to drive concrete progress where it is needed and enable the joint programme to improve its strategic focus. The

[1]The goals are (1) sexual transmission of HIV reduced by half, including among young people, men who have sex with men and transmission in the context of sex work; (2) vertical transmission of HIV eliminated and AIDS-related maternal mortality reduced by half; (3) all new HIV infections prevented among people who use drugs; (4) universal access to antiretroviral therapy for people living with HIV who are eligible for treatment; (5) tuberculosis deaths among people living with HIV reduced by half; (6) people living with HIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support; (7) countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half; (8) HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions; (9) HIV-specific needs of women and girls are addressed in at least half of all national HIV responses; (10) zero tolerance for gender-based violence.

annex provides the new UNAIDS strategy at a glance. The strategy formed the basis for the new political declaration on HIV/AIDS adopted at the United Nations General Assembly high-level meeting on AIDS in June 2011.

6. Below are some illustrative examples of the results generated by UNDP and UNFPA contributions to development, under each of the three strategic directions of the UNAIDS strategy 2011-2015, as well as challenges and steps to address them.

7. Since 2008, nearly 70 UNDP country offices have implemented programmes linked to the four HIV outcomes of the UNDP strategic plan, and an additional 30 countries are estimated to implement HIV activities as part of other thematic or cross-practice programmes. Analysis of independent evaluative evidence and reporting from country offices outlines significant results in addressing HIV. In particular, the evidence highlights successful approaches in building the capacity of local institutions, advancing gender equality, and promoting multi-stakeholder engagement, South-South cooperation and collaboration with United Nations agencies. The evaluations point to noteworthy cross-practice work, indicating that some of the strongest HIV results have been achieved where there are linkages to other thematic areas.

8. Given that about 80 percent of HIV infections are transmitted sexually or are associated with pregnancy, childbirth and breastfeeding, UNFPA has implemented a strategy that prioritized the allocation and use of its unified budget and workplan (UBW) resources towards building the Fund's dedicated HIV capacity at country and subregional levels. This capacity-building strategy to enhance its support to countries' HIV-prevention efforts was launched in 2006.A review in 2008 concluded that the scope, intensity and quality of the UNFPA contribution to HIV prevention have undergone a significant positive shift. In 2011, the strategy is under review to ensure an integrated approach to more efficiently intensify the Fund's work with countries to link HIV responses to broader development, human rights and humanitarian programming and to sexual and reproductive health (SRH).

**Revolutionizing HIV prevention**

9. UNDP supported 21 countries and two regions for mainstreaming HIV into national and sector development plans and processes, Poverty Reduction Strategy Papers (PRSPs) and Millennium Development Goal (MDG) plans. A draft legislative review report on integrating health and social issues (particularly HIV and gender) into environmental impact assessments (EIAs) in the Southern and East Africa regions has been produced by the Southern Africa Institute for Environmental Assessment and supported by UNDP. Partnering countries include: Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Uganda and Zambia. EIAs are a practical platform through which the social impacts (HIV and gender) associated with capital projects can be better understood and addressed through a multisectoral approach in a sustainable manner. The initiation of this project has led to strengthened collaboration across ministries. In all countries, links between gender, HIV and capital projects are being identified and better understood.

10. Technical assistance and policy guidance on men having sex with men (MSM), transgender people and sex work, as well as funding and fund-raising support was provided to over 37 countries. Building on work initiated in 2009, UNDP continued to provide advisory support to programmes in Argentina, Burkina Faso, Togo, Lesotho, Fiji, Philippines and Ukraine on strategic information for MSM and transgender people, human rights protection and strengthening capacity and partnerships for scaling up services for MSM and transgender people. These programmes have resulted in scaling up national efforts to address the needs of these typically underserved populations – for example, in the Philippines there is now a specific component in the national HIV programme focusing on MSM and transgender people.

11. Addressing the SRH needs of men and women, UNFPA continues to intensify access to male and female condoms and promote their correct and consistent use. The Global Condom Initiative was expanded

to 74 countries in 2010, up from 55 countries in 2008 and moving closer to its 100 country target. UNFPA continues to be one of the largest suppliers of male and female condoms to low-income countries (68 million and 14 million, respectively, in 2009). A condom demand-generation framework was field-tested in the Caribbeansubregion resulting in the drafting of condom demand-generation strategies in Belize, Suriname and St. Lucia. Condom demand-generation initiatives were also completed in four high-prevalence countries in Southern Africa, namely,Botswana, Lesotho, South Africa and Swaziland.In 2011, UNFPA intensified efforts towards achieving the UNAIDS targets of increasing condom use among young people by 50 per cent and this will continue to be a programmatic priority.

12. To scale up HIV testing for young people in South Africa, UNFPA forged a partnership with LoveLife and Soul City, to support a national HIV Counselling and Testing Campaign (HCT) for 12-14 year olds reaching 8,445,000 young people. In Barbados and Kazakhstan, advocacy with policymakers was undertaken to remove the legal barriers that prevent youth below the age of 18 from accessing SRH services without parental consent. In Belize, UNFPA support to the Young Women's Christian Association (YWCA) to establish a youth-friendly space for young girls has significantly improved access to counselling, SRH information and condom use.

13. Globally, UNFPA continued to strengthen partnerships, build the evidence base, support capacity development and provide technical assistance to support young people's access to the comprehensive package of adolescent SRH services and sexuality education. The 2011 target for proportion of countries with secondary school curricula including gender-sensitive life skills-based SRH and HIV prevention has already been surpassed in 2010. Examples of results from UNFPA support include Nepal where adolescent and youth SRH was included in the Government's health-sector implementation plan; and Viet Nam where national adolescent sexual and reproductive health (ASRH) guidelines were developed for out-of-school youth. In Colombia and Mozambique, UNFPA-supported programmes made the important switch from being donor-supported to government-owned. In the Syrian Arab Republic and Egypt, UNFPA supported sexuality education through culturallysensitive approaches.

14. Currently, UNFPA and partners are working to establish a network of regional and national experts to respond to training and technical assistance requests in sexuality education. As a first step, a situational analysis was carried out to assess the content, quality and the method of delivery of the current school-based sexuality education programmes in 10 East and Southern African countries so as to guide future curriculum revisions. The results fed into a workshop co-organized by UNFPA, UNICEF, UNESCO, and the University of KwaZulu-Natal which built the capacity of 70 curriculum-development specialists from the Ministries of Education and United Nations staff responsible for youth from 10 Southern African Development Community(SADC) countries (Botswana, Kenya, Lesotho, Malawi, Namibia, South Africa, Swaziland, Uganda, Zambia and Zimbabwe) to design and implement effective sexuality education and HIV prevention among young people in the educational settings. As a result, a regional training manual on sexuality education, using participatory training methodology, is being developed and will be used to create a critical mass of competent sexuality educators.

15. Recent evidence showing HIV as the leading cause of death in women of reproductive age demands strengthened awareness of the interconnection of MDGs 3, 4, 5 and 6 and concerted efforts to support the integration of HIV and SRH. To date, 25 countries have been supported to develop and implement national plans to integrate SRH and countries have reported improved linkages between HIV programmes and efforts to prevent gender-based violence (GBV). Technical support was provided to 61 countries to scale up programmes to implement prevention of mother-to-child transmission (PMTCT) and service integration – family planning provides a solid entry point with UNFPA offices reporting that 70 per cent of the countries had included family planning in situation analyses, and 49 per cent had allocated a budget for it in their national plans.

16. Key challenges remain and will impact reaching the UNAIDS strategy goals. In 2010, more evidence emerged of the prevention benefits resulting from scaled-up treatment. These findings underscored not only the need to accelerate the expansion of treatment access, but also the critical need to link HIV prevention and treatment at the levels of strategic planning, service delivery, and impact evaluation. This will require stronger measurement and data gathering on prevention as a whole, both qualitative and quantitative. 'Treatmentforprevention' needs to be used in combination with other HIV-prevention options as it is an enhancement of the HIV-prevention package and not a replacement.

17. On the issue of integration, linkages between HIV and SRH continue to be challenging in many countries. Often the focus is on service-level integration with less attention paid to the wider structural and human rights issues. Ineffective logistical and supply systems are also obstacles to effective service delivery. For example, interruptions in the supplies of key commodities (antiretroviral medicines, regimens for opportunistic illnesses, HIV testing kits, condoms, etc.) impede effective responses and underscore the need for further strengthening of national and subnational systems for procurement and supply management. As regards elimination of mother-to-child transmission of HIV and universal access goals, these will not be attained unless countries and communities reach the most marginalized members of society and serve their needs. Greater political support, focused technical support and more integrated services are required to ensure programmes are scaledup in countries where progress continues to lag. A comprehensive approach, with practical standardized procedures supplemented with evidence on the benefits of integration, is critical in convincing stakeholders to scale up programmes.

18. Prevention information and programming need to be delivered through a continuum of age- and context-appropriate programmes, for which the design has seen young peoples' participation and inputs, including sexuality education as a useful means of improving health outcomes for young people. Removing policy and legal barriers to youth-friendly services so that young people are not excluded reduces their risk of exposure to HIV. Working towards measurable targets (for example, on comprehensive knowledge, HIV testing and condom use in young people) in priority countries will help to build greater accountability and leverage for results in reducing new infections.

**Catalysing the next phase of treatment, care and support**

19. As a Global Fund to Fight AIDS, Tuberculosis and Malariaprincipal recipient, UNDP helped to develop country capacity to effectively implement large-scale HIV, tuberculosisand malaria programmes in 29 countries in 2010. Capacity development support for national stakeholders has been a key priority, with formal capacity development plans being prepared for all new grants managed by UNDP, in collaboration with country partners. UNDP has served as a principal recipient in a total of 37 countries between 2003 and 2010. In 12 of these countries, the principal recipient role was handed over to a national entity, reflecting achievements in capacity development. Despite often serving as principal recipient in country contexts with the highest levels of risk, UNDP grant performance is significantly above average. Since 2003, UNDP contributed to providing community outreach for HIV, tuberculosis and malaria prevention to 28 million people. HIV counselling and testing was provided for nearly 4.8 million people, in addition to antiretroviral treatment for 213,000 people living with HIV.[2]Programmes also resulted in detection and treatment of 700,000 cases of tuberculosis, distribution of 11 million bed nets, and treatment of 26 million malaria cases.

20. UNFPA supported the development of specific guidance for addressing issues relevant to youth and sex workers for use in preparing Round 10 Global Fund HIV proposals.It provided technical support to South Africa, Swaziland and Zambiato integrate SRH and HIV; and to 20 countries for PMTCT of HIV, including consultation and joint technical missions.

[2]HIV treatment figure represents current number of people on antiretroviral treatment for active grants.

21. UNDP supported 17 countries and two regions to build capacity for adoption of enabling trade and health policies and legislation. In Ukraine, for example, the Government was supported by UNDP to incorporateTrade-Related Aspects of Intellectual Property Rights(TRIPS) flexibilities into their national legislation. If these are adopted, there could be a substantial reduction in the costs of antiretroviralsand other medicines. Also, in the case of Ukraine, if the TRIPS flexibilities are adopted, more generics could be used, which in some cases could account for over 90 per cent cost savings thereby allowing many more people to be put on treatment. In the United Republic of Tanzania, UNDP, in partnership with civil society and the German Agency for International Cooperation (GIZ) organized two meetings on the proliferation of anti-counterfeiting legislation in the East African Community (EAC) – covering Burundi, Kenya, Rwanda, Uganda and the United Republic of Tanzania. The meetings were attended by government representatives, Members of Parliament, scholars and civil society from all EAC countries and raised awareness on the public health implications of anti-counterfeit legislation. They resulted in the adoption by the EAC Secretariat of UNDP proposals to amend the draft EAC anti-counterfeiting bill in a public health-sensitive fashion. This will guarantee the continued use of generic medicines in the EAC countries which account for 90 per cent of all medicines consumed in the region.

22. Poverty and exclusion are key aspects to address when tackling vulnerability to AIDS. This has led the global community to recognize that we need not an AIDS-exclusive but an AIDS-sensitive approach to social protection. In India, UNDP supported the creation, expansion and reform of multiple HIV-sensitive social protection programmes in several states, reaching over 77,000 people in a six-month period in 2010. The analytical foundation for these programmes was laid out in 2006 with a socio-economic impact study, which showed considerable negative impacts of HIV on employment, income, savings and school attendance in affected households. In follow-up, UNDP launched a multipronged strategy of advocacy and technical support involving the National AIDS Control Organization, state offices and civil society organizations, including networks of people living with HIV. As a result, in the State of Rajasthan, the widow-pension scheme was reformed so that women widowed by HIV would be eligible to receive a monthly pension irrespective of age. Other states in India are now following suit. Across all states with modified pension schemes, approximately 23,000 women benefited from this change in 2010. Moreover, states have been increasingly covering transportation costs for HIV treatment. In six months in 2010, over 31,000 people benefited from the programme. Other notable reforms include states where people with HIV now have access to subsidized food, housing and health care – all of which were previously restricted to those below the poverty line. The Ministry of Labour has also removed an HIV-exclusion clause from special health insurance schemes for informal workers.

23. Many countries do not have national social protection programmes and for those that do there needs to be a thorough review of how to make laws, policies and programmes more sensitive to the needs of those affected by and living with HIV. Access to services is restricted for many due to general conditions of poverty, combined with stigma and discrimination. Although in some settings there exists a continuum of care between HIV-treatment sites and community-based organizations, in reality this is very difficult to ensure due to a variety of factors including lack of political will and resources, lack of capacity of community groups, and a lack of understanding between community groups and health-care workers.

24. While the health sector must be at the centre of treatment, care and support scale-up efforts, many countries are still not strategically leveraging and coordinating with the relevant ministries. In addition to the role of trade and social protection policies as described above, other key contributors to scalingup care and support can include ministries of women or gender, which address the disproportionate role of women as caregivers, and ministries of the interior or home affairs, which help to facilitate access to services for marginalized groups.

**Advancing human rights and gender equality**

25. UNDP, together with the UNAIDS Secretariat and the Global Fund, published an analysis of access to justice programming in Rounds 6 and 7 HIV proposals and grants, which successfully influenced

inclusion of a specific objective and operational plan on human rights and equity in the new Global Fund strategy.

26. In June 2010, UNDP launched the Global Commission on HIV and the Law on behalf of the UNAIDS family. The Commission's aim is to develop evidence-informed and human rights-based recommendations which will support countries to create and maintain enabling legal environments for effective HIV responses. The discussions and follow-up actions identified through the Commission's regional dialogues across six regions, held in 2011, will further inform and strengthen UNDP work in this important area. The aim of the regional dialogues is to generate policy dialogue, with a view to giving voice to the critical HIV-related human rights and legal issues in the region. The regional dialogues will inform the deliberations of the commission through submissions and evidence-informed inputs and by engaging policy and lawmakers, law enforcement and community perspectives. The regional dialogues will also contribute to enhancing awareness, engagement and ownership within regions on the actions that are required to effect real change on issues of human rights and law that can support improvements in people's lives and health. There are close links between the gender work of UNDP and the Global Commission on HIV and the Law. One of the three main areas the Commission is investigating concerns laws which sustain or mitigate violence and discrimination lived by women.

27. A progress report on the implementation of the action framework and the *UNAIDS Agenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV* was presented to the 27th PCB. The 28th PCB meeting further discussed gender sensitivity of AIDS responses. Launched in March 2010, the initiative has achieved considerable results: 55 countries have launched the agenda for women and girls, with 45 countries already reporting on activities directly related to the agenda. A total of $6.1 million has been allocated towards the initiative in 2010, including $4.5 million in country support.

28. PCB members welcomed the progress report and cited the operational plan as a unique opportunity to ensure that national responses meet the needs of women and girls. The PCB specifically welcomed efforts by UNAIDS to incorporate comprehensive sexuality education policies and programmes in its 2011-2015 strategy, as well as UNAIDS efforts to address male gender-related obstacles to HIV and SRH services. Further progress was urged, and calls were made for broader leadership on women, girls and HIV, with political rhetoric matched by sufficient resources.

29. Following up on UNDP responsibilities within the *UNAIDSAgenda for Accelerated Country Action for Women, Girls, Gender Equality and HIV*, leadership capacity development for women living with HIV was undertaken in 23 countries across six regions, resulting in increased partnerships between HIV-positive women's organizations/networks and other key national stakeholders. In addition, the capacity of national networks of women living with HIV has been strengthened to more effectively engage in universal access processes/reporting and MDG reporting/advocacy in 14 countries.

30. Integrating responsibilities for the UNiTE Campaign and the Agenda for Women and Girls, UNFPA supported 42 countries to design, implement or evaluate prevention, treatment, care and support programmes specifically intended to empower women and girls; and 26 countries to develop and/or implement HIV-related policies that specifically address GBV and other actions promoting gender equality. In Jamaica, a Men's Desk was created to manage requisite interventions at the Bureau of Women's Affairs which has increased mobilization of Jamaican men in the advocacy and implementation of programmes to reduce GBV and improved male involvement in securing equality and rights of women. Networks of people living with HIV were supported in nearly 80 countries with an emphasis on women living with HIV.

31. At the end of 2010, UNFPA led the work of the inter-agency working group on gender equality and HIV to build the capacity of 16 countries across three regions to jointly develop and operationalize, with men and boys, strategies addressing social norms around gender, violence, and sexual relationships. UNFPA supported the "Working with men for HIV/AIDS prevention and response" workshop for 92

participants from 30 countries that resulted in the development of an Africa regional framework on working with men and boys for the promotion of gender and reproductive health (to include HIV/AIDS). Although the importance of engaging men and boys to move towards gender equality is recognized, the challenge remains to engage them as partners towards this end as well as for their own sexual and reproductive health.

32. UNDP has led an inter-agency initiative, which includes UNFPA, called 'Universal Access for Women and Girls Now!' in 10 countries to support countries to address gender equality in national HIV responses. An example of success includes the integration of a clear gender component and commitment to address GBV in Zambia's new *National AIDS Strategic Framework (2011-2015)* andthe creation of a new gender adviser post in the Zambia National Council to ensure ongoing integration of gender into the national AIDS response.

33. Key challenges for implementation of the action framework include: the need for long-term political and financial commitments for women, girls and HIV; the need to strengthen SRH services and link them to HIV; high rates of GBV; and the need to increase the engagement of men. Capacity development is central to the success and sustainability of this agenda. Furthermore, experience to date underscores the need for better evidence and improved monitoring systems.

34. It was noted that UN-Women represents a potential opportunity to strengthen the United Nations system's engagement on the above-mentioned issues. At its March 2011 meeting, the Committee of Cosponsoring Organizations (CCO) welcomed the interest of UN-Women to join the Joint United NationsProgramme on HIV/AIDS and agreed to the initiation of the formal application process for UN-Women in accordance with criteria and process agreed by the PCB in 2004 (UNAIDS/PCB(15)/04.8). In the meantime, the joint programme continues to focus on women and girls and to promote women's rights and gender equality.

35. During the development of the UBRAF, UNAIDS ensured that key actions, indicators and budgetary allocations pertinent to continued progress in implementing the action agenda were reflected, including but not limited to the integration of HIV and SRH services. Member States requested that further monitoring be carried out in coordination with Member States, and with the participation of women living with HIV and civil society and that it be reported to the PCB through the UBRAF. They also requested a midterm review of the agenda in December 2012.

36. UNAIDS was asked to partner with national stakeholders to document models of best practice of collaboration between the AIDS and women's movements in addressing the HIV-related needs of women and girls. The PCB also requested UNAIDS to collaborate with key stakeholders to promote and facilitate improved linkages between SRH, human rights and HIV and encouraged further partnership with networks that work on HIV and gender-equality issues with men and boys as well as women and girls.

37. In 2011, UNFPA and UNDP supported over 50 countries to enhance human-rights protection and service access for sex workers and their clients, MSM and transgender people. These efforts have increased coordination and harmonization among sex worker networks and organizations focused on HIV and sexually transmitted infection prevention, SRH and the links between SRH, GBV and human rights. UNFPA and the Asia Pacific Network of Sex Workers (APNSW), together with partners, organized the first Asia Pacific regional consultation on HIV and sex work, hosted by the Royal Thai Government, with participation from Cambodia, China, Fiji, Indonesia, Myanmar, Pakistan, Papua New Guinea and Thailand.The consultation resulted in the development of eight draft country-level action plans on HIV and sex work; the setting of a regional agenda for responding to the HIV epidemic among sex workers and their clients for implementation during2010-2013; strengthened technical capacity of the APNSW Secretariat through the employment of a full-time director and a policy officer; and the establishment of regional dialogue between the governments and national-level dialogue between the government and sex workers.

38. Issues surrounding key populations hamper progress. Data shows that most countries continue to allocate inadequate resources to programmes for key populations. Stigma, discrimination and homophobia continue to persist, coupled with inadequate political commitment. In some countries the effects of having weak civil societies impede efforts to address the HIV-related needs of key populations. A lack of both quantitative and qualitative data means theoretical frameworks around gender, sexuality and identity are weak, leading to superficial understandings of needs and behaviours which in turn result in ineffective programmes. Furthermore, effective responses and efforts to work in partnership with key populations can be hindered by a range of situations, for example, compulsory drug treatment, or the criminalization of sex work and same-sex relations. Recent policy changes linked to more effective political leadership and more targeted resource allocations have helped to expand access to evidence-informed services for key populations, and demonstrate that progress is possible. A supportive environment must be created for key populations to participate in the planning, delivery and evaluation of strategies and programmes that affect their lives. Effective attention to the needs of key populations also requires a holistic approach, including anti-stigma efforts and work with law enforcement agencies and other stakeholders to address macrolevel issues.

39. The 27th PCB meeting discussed AIDS, security and humanitarian responses. Under the UNAIDS Division of Labour, UNFPA and UNDP have been working jointly with partners on addressing HIV/AIDS in humanitarian situations. The need to scale up this work and strengthen programmes that address HIV and sexual violence in conflict settings was recognized through the adoption in June 2011 ofSecurity Council resolution 1983 (2011)[3].

40. Under the framework of the above-mentioned Security Council resolution, UNDP and UNFPA, in collaboration with the Department of Peacekeeping Operations (DPKO), UNAIDS Secretariat and cosponsors, will build on past initiatives and continue to strengthen ongoing work such as:

- Integration of gender and HIV interventions in disarmament, demobilization and reintegration programmes. Joint programmes have reached male and female ex-combatants, as well as women associated with armed forces and receiving communities during reintegration processes in Comoros, Côte d'Ivoire, Democratic Republic of the Congo, Indonesia, Liberia, Nepal, Sudan, Sierra Leone and South Sudan.

- Provision of essential reproductive health commodities and supplies to all refugee populations and camp settings managed by UNHCR in approximately 25 countries per year (as per an agreement between UNFPA and UNHCR).

- Training of national uniformed services before their deployment to peacekeeping missions and partnership with DPKO on training initiatives for peacekeepers on HIV and GBV.

- Partnering with relevant agencies to establish and/or strengthen programmes for host communities on prevention of sexual violence and HIV in conflict and post-conflict settings.

41. The adoption of Security Council resolution 1983 (2011) shows high-level commitment from Member States for combating HIV/AIDS in humanitarian contexts and presents new opportunities for

[3] The resolution, among other provisions, "Encourages the incorporation, as appropriate, of HIV prevention, treatment, care, and support, including voluntary and confidential counselling and testing programmes in the implementation of mandated tasks of peacekeeping operations, including assistance to national institutions, to security sector reform (SSR) and to disarmament, demobilization and reintegration (DDR) processes, and the need to ensure the continuation of such prevention, treatment, care and support during and after transitions to other configurations of United Nations presence". This resolution not only recognizes that "coordinated international action continues to be required to curb the impact of the HIV epidemic in conflict and post-conflict situations" but also provides directives for the United Nations and Member States on implementation.

UNFPA and UNDP to sustain/expand programmes and partnerships. As pointed out in the progress report on implementation of Security Council resolution 1308 (2000), *On the Frontline: A review of programmes that address HIV among international peacekeepers and uniformed services 2005-2010*"... the changing landscape of threats to international, peace and security and the evolving evidence on the relationship between AIDS and security have created new challenges and opportunities to further strengthen these actions and contribute to United Nationsefforts to prevent conflict and build peace".Discussions between the key actors (UNAIDS Secretariat, DPKO, UNDP, UNFPA, UNODC) will soon take place to determine a clear division of responsibilities and timelines in order to implement Security Council resolution 1983 (2011).

## III. UNAIDS PCB decisions and recommendations of note for UNDP and UNFPA

### UNAIDS strategy

42. The 27th meeting of the PCB officially adopted the new *UNAIDS 2011-2015 Strategy: Getting to Zero*, which presents a transformative agenda for the global response. The strategy aims to increase focus and improve efficiency in order to radically reduce the number of new infections, expand treatment access and reduce stigma and discrimination. It is intended to facilitate strategic partnerships, support country ownership, engage emerging economies, facilitate South-South and triangular cooperation, and usher in a new approach to financing the response. The strategy emphasizes mutual accountability in the response, improving broad ownership, strengthening community systems, and promoting activism. It reflects the transition from short-term technical support to the development of lasting capacity and resilient nations, as well as enhanced efforts to link the AIDS response with broader health and development efforts.

43. Member States emphasized that all cosponsors were encouraged to link their strategies to the new UNAIDS strategy. This continues as a work in progress with WHO, WFP, ILO and UNESCO having already revised their HIV strategies and policies to make specific links to the UNAIDS strategy. UNFPA is set to do this with an upcoming revision of its strategic guidance on HIV and is taking the UNAIDS UBRAF into consideration within the follow-up to the midterm review of its strategic plan and revision of the accompanying development results framework.The new UNAIDS strategy will also inform the next UNFPA strategic plan, 2014-2017. UNDP will update its current corporate strategy on AIDS to reflect the new UNAIDS strategy, for 2012 and 2013. In addition, the new UNAIDS strategy will inform the incorporation of HIV and AIDS work in the new UNDP strategic plan for 2014 and beyond.

44. One challenge of note is the flattening international support for HIV combined with competing needs and a growing population of people living with HIV placing significant pressure on the HIV response and threatening the sustainability of recent gains. In addition, the heavy dependence of many countries on external support potentially places national responses in jeopardy. Ten years after the adoption of the time-bound targets in the 2001 Declaration of Commitment on HIV/AIDS, human resource and institutional capacity constraints exist in technical and managerial areas, which continue to undermine national responses. Funding the response to HIV is a shared responsibilitythat demands continued support from international donors, greater allocations and political commitment from domestic governments, stronger leadership from emerging economies and the private sector, and intensified programmatic focus on improving efficiency and maximizing impact.

### Unified budget, results and accountability framework 2012-2015

45. The UNAIDS strategy will be implemented through various mechanisms, including the 2012-2015 UBRAF and a revised UNAIDS Division of Labour. The UBRAF was the main item on the agenda of the 28th meeting of the PCB replacing the thematic session. The UBRAF is structured around the UNAIDS strategy, its 10 strategic goals and strategic functions aim to contribute to achieving the UNAIDS long-term vision of zero new HIV infections, zero AIDS-related deaths, and zero discrimination.

46. The UBRAF describes outcomes, outputs and deliverables for the joint programme, the allocation of resources against these with geographical reference, and how progress will be monitored. As such, it presents the comprehensive results architecture for the joint programme, incorporating clearly defined baselines and outcomes, identifying each cosponsor's contributions, and specifically focusing on country progress.

47. The UBRAF is composed of three components:

(a) A business plan that provides a framework to capture the contributions of the joint programme to support the operationalization of the UNAIDS strategy 2011-2015.The business plan describes the rationale, objectives and expected results of the joint programme. Cosponsors and the UNAIDS Secretariat will develop annual rolling workplans for the detailed implementation of the UBRAF, strengthening linkages to the planning processes and results frameworks of the cosponsors. Given the changing nature of the epidemic and the need for greater focus, UNAIDS will concentrate its efforts both programmatically and through intensifying efforts in 20+ countries identified in the UNAIDS strategy (see figure 1).

Figure 1: Overview of 20+ countries

- **Brazil**
- **Cambodia**
- **Cameroon**
- **China**
- **Democratic Republic of the Congo**
- **Ethiopia**
- **India**
- **Kenya**
- **Malawi**
- **Mozambique**
- **Myanmar**
- **Nigeria**
- **Russian Federation**
- **South Africa**
- **Thailand**
- **Uganda**
- **Ukraine**
- **United Republic of Tanzania**
- **Zambia**
- **Zimbabwe**

- **Would address**
  - Over 70% of new global HIV infections
  - Over 80% of the global gap in ART for eligible adults
  - Over 75% of the global gap in prevention of vertical transmission
  - Over 95% of the global burden of HIV-associated TB
  - Major HIV epidemics driven by injecting drug use (over half of the 20 low- and middle-income countries estimated to have more than 100 000 people who inject drugs and an estimated HIV prevalence among them exceeding 10%)
  - Laws that affect the HIV response, including laws that restrict travel for people living with HIV (14 of these countries have 3 or more such laws)
- **Would boost aid effectiveness**
  - Enhance the implementation of more than US$ 5.1 billion in active HIV grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria
  - Leverage funding from the United States President's Emergency Plan for AIDS Relief (more than US$ 7.4 billion for 2007–2009)
- **Would engage**
  - All five BRICS countries (Brazil, Russian Federation, India, China, South Africa)

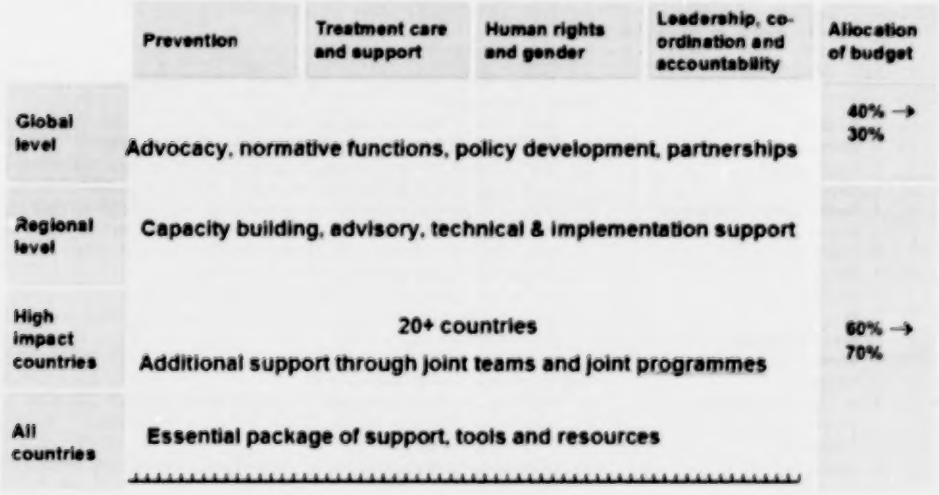
* These countries meet three of the following five criteria according to independent data sources: (1) >1% of the people newly infected with HIV globally; (2) >1% of the global gap in antiretroviral therapy for adults (CD4 count <350/ml); (3) >1% of the global burden of HIV-associated TB; (4) estimated to have more than 100 000 people who inject drugs and an estimated HIV prevalence among them exceeding 10%; and (5) the presence of laws that impede universal access for marginalized groups, including sex workers, men who have sex with men, transgender people, and people who inject drugs.

(b) A results and accountability framework that will measure the achievements of the joint programme and provide a clear link between investments and results.Theresults and accountability framework will ensure accountability in both programmatic results and in delivering value for money. The PCB requested the joint programme to further strengthen the framework through a consultative process with all constituencies, the results of which will be reported to the 29th PCB meeting. Implications for UNDP and UNFPA include review and refinement of indicators as members of the Cosponsor Evaluation Working Group (CEWG) and the UNAIDS Monitoring and Evaluation Reference Group (MERG)

Implementation of the framework will be reported to the PCB annually, including information, supported with indicators,on resourcing and engagement of civil society.

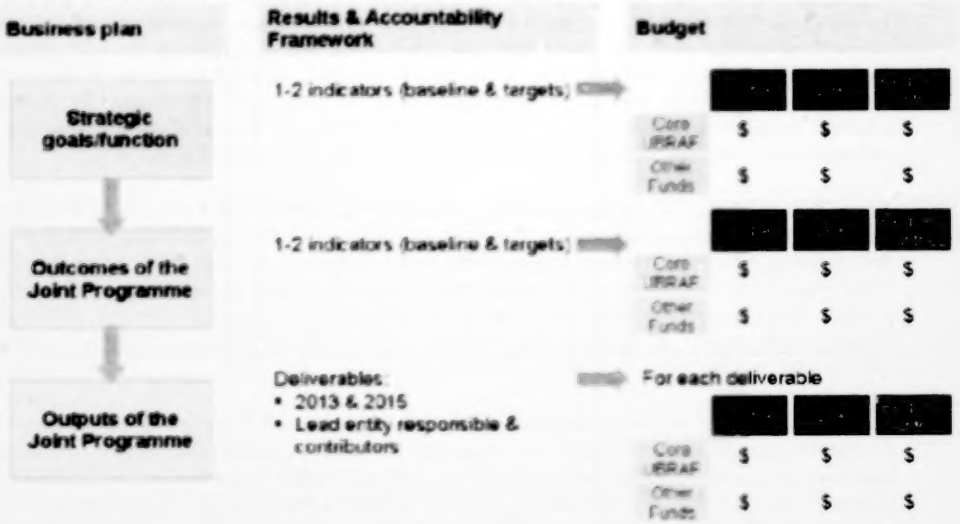
(c) A core budget to catalyse the contributions of the cosponsors and fund the UNAIDS Secretariat in 2012-2013 to translate the goals of UNAIDS strategy into action and results.The PCB approved the core budget of $485 million for 2012-2013, which means the budget remains at the same level as in 2010-2011 and 2008-2009. This represents a decline in real terms and highlights the continued catalytic and leveraging nature of the UBRAF and efforts to ensure value for money. An amount of $164 million goes towards the 10 UNAIDS cosponsors and $320 million to the UNAIDS Secretariat. Core budget allocations to cosponsors are intended to leverage other budgets to be raised by cosponsors for AIDS-related work. Over the next two bienniums, the aim is to increase the amount of core UBRAF resources spent at regional and country level to 70 per cent to maximize the impact of all cosponsor and UNAIDS Secretariat resources dedicated to the AIDS response.

Figure 2: Current and target allocation of core UBRAF resources




48. The UBRAF links all elements of the business plan, the results and accountability framework and the budget to produce a chain of results to support the achievement of the UNAIDS strategy 2011-2015. The figure below summarizes the business plan, results and accountability framework, and budget, and the links between them. The support and guidance of the UNDP/UNFPA/UNOPS Executive Board in aligning the respective UNDP and UNFPA strategic plan revisions with the UBRAF will ease the alignment challenges.

Figure 3: Links between the different elements of the UBRAF




**Progress report on implementation of the second independent evaluation**

49. The second independent evaluation of the Joint United Nations Programme on HIV/AIDS called for the development of a new UNAIDS mission, vision, strategy and unified budget, results and accountability framework. In addition, the joint programme revised the UNAIDS Division of Labour to enhance efficiency and effectiveness, leverage respective mandates and resources, and promote mutual accountability at global, regional and country levels. The Division of Labour identifies convening and partnership roles and responsibilities for each of the 10 UNAIDS cosponsors. The UNAIDS Secretariat is not convening any of the 15 Division of Labour areas, but will facilitate and promote coordination and cohesion in advocacy, strategic information, partnership, mutual accountability, and the mobilization of core resources to achieve results in all the areas.

50. Under the revised Division of Labour, UNDP is assigned as a convenoronthe priority area addressing human rights and the legal environment, and as a co-convenor with UNFPA on women and girls and most-at-risk populations.[4]Furthermore, UNFPA is co-convening with the World Bank on sexual transmissionof HIV and with UNICEF on young people. The convening and partnership roles designated to UNDP are well aligned to the outcome areas of its strategic plan, and the broader mandate of UNDP in poverty reduction, governance, gender equality and crisis prevention and recovery. Similarly, the co-convening roles for UNFPA are fully aligned with its mandate and its strategic plan focus on universal access to sexual and reproductive health, reproductive rights, women and gender equality, young people and the focus on reaching marginalized and excluded populations.

51. Overall, there are opportunities to significantly improve UNAIDS collective performance and impact as a result of the adoption of the revised Division of Labour. The increase in the number of joint United Nations teams and joint programmes of support offers the potential to improve the coherence, coordination

[4]UNDP convenes on "remove punitive laws, policies, practices, stigma and discrimination that block effective responses to AIDS", and co-convenes with UNFPA on "meet the HIV needs of women and girls and stop sexual and gender-based violence" and "empower men who have sex with men, sex workers and transgender people to protect themselves from HIV infection and to fully access antiretroviral therapy".

and effectiveness of United Nations efforts at country level. The broader effort to implement recommendations of the SIE will also lead to changes across UNAIDS, not least in the new and four-year format of the UBRAF. While queries have been posed by some donors regarding potential changes to the Division of Labour under the assumption that UN-Women would be joining the joint programme,it is expected that formalities will take place in due course. However, agencies are already working closely with UN-Women on various issues and, where present at country level, UN-Women is included in the discussions and decisions on the process of adapting the Division of Labour at country level based on local circumstances and needs, taking into account the comparative advantages of all partners.

52. The finalization of the technical-support strategy had been deferred to the 27th PCB meeting. The technical-support strategy outlines key actions by the joint programme for scaling up technical support and strengthening the overall technical support marketplace. Enhanced emphasis is placed on the effectiveness of technical support and on the cost-effective delivery of such support through harmonized and accountable systems. In particular, UNAIDS will focus its technicalsupport efforts on long-term skills transfer and capacity development at national and regional levels, and on aligning differing technicalsupport architectures and mechanisms within the joint programme.

53. PCB members requested additional details on plans for technical support. It was agreed to include a substantive agenda item reviewing and analysing the state of sustainable capacity development and technical support in the joint programme and to undertake further discussion of the UNAIDS technical-support strategy at the 29th meeting of the PCB. Linked to the technical-support strategy in terms of capacity development was the reiteration of the need for a distinct partnership strategy focused on civil society and people living with HIV as noted in the SIE. Work will continue on its codification, along with identification of UBRAF indicators, over the next six months in collaboration with civil society partners. Challenges include ensuring a clear understanding of the expectations and objectives of each potential partner as a principle of effective partnership and ensuring that these expectations and objectives are aligned with UNAIDS strategic goals and national programme priorities. Furthermore, recent experience highlights the willingness of many multinational companies to partner on social development work with NGOs to strengthen corporate social responsibility programmes and explore opportunities to work with smaller private sector enterprises on HIV.

54. Finally, the PCB was informed that, following extensive consultation and a thorough review of pertinent benefits and costs, it had been determined that the best option for the UNAIDS Secretariat was to move to a single administrative system within the framework of WHO regulations and rules. Previously, the Secretariat used the WHO and UNDP administrative systems, respectively, at headquarters level and country level. All UNAIDS staff will now be subject to the same set of staff rules and connected to the same electronic platform. Costs associated with moving to a single administrative system will be absorbed within the Secretariat component of the unified budget and workplan. It is anticipated that a single administrative system will enable the UNAIDS Secretariat to achieve important efficiencies and avoid duplication.

## IV. The way forward

55. In view of the context, UNDP is adjusting HIV programming to respond to the identified challenges and scale up successes. First, recognizing the value of linking action on HIV and broader development efforts, UNDP will prioritize implementation of cross-thematic programmes that address HIV together with key priorities such as advancing gender equality, access to justice, and economic empowerment. This will involve development of cross-practice strategies and joint workplans, as well as operationalization of practical programming guidance. Secondly, while good progress is being made in developing the capacity of national entities to take over implementation of Global Fund, HIV, tuberculosis and malaria grants, UNDP will significantly scale up attention to longer-term capacity development. Moving forward, capacity development assessments and plans prepared in collaboration with national stakeholders will be an integral

component for all new Global Fund programmes managed by UNDP. Thirdly, building on the MDG assessment, which points to the benefits of linking HIV and health strategies, UNDP will look to promote cost-effectiveness by leveraging existing successful HIV programming for broader health MDGs. This will include drawing on experience in supporting large-scale implementation, capacity development and governance to accelerate MDG progress. Finally, it will be important to ensure that evaluations more consistently inform programming decisions, and that successful HIV initiatives are either sustained and scaledup, or handed over to partners in cases where UNDP terminates support.

56. In light of the reality that thetwotop causes of death in women of reproductive age globally are complications related to pregnancy and childbearing and HIV/AIDS, and given the fact that maternal mortality worldwide would have been lower by about 6 per cent in 2008 in the absence of HIV, UNFPA will continue its efforts to reduce maternal mortality. This will include strengthening mechanisms that actively link efforts to reduce maternal mortality with those that respond to the AIDS epidemic; fostering greater collaboration and integrated approaches and developing evidence-informed and rights-based programmes; and placing maternal health within a continuum of care that integrates a comprehensive range of interventions to impact maternal health outcomes, including those related to HIV. UNFPA will continue to support efforts for the meaningful engagement of women and girlsat every stage of national HIV responses to ensure that their needs and rights are well addressed and monitored; and that they have access to an essential package of quality SRH services and are treated with dignity and respect, free of violence, coercion, stigma and discrimination. Based on the evidence of what works to prevent HIV infections in adolescents and young people, UNFPA will support comprehensive HIV and SRH interventions for young people inclusive of: delaying sexual debut; abstaining from sex; correct and consistent use of male and female condoms; medical male circumcision; reduction of multiple concurrent sexual partners; and effective communication for social and behavioural change.

57. UNFPA will continue to support the improvement of national, regional and global comprehensive condom programming to increase access to and demand for male and female condoms. UNFPA will support governments to develop strategies that specifically address the sexual and reproductive health needs of MSM, sex workers and transgender people based on epidemiological and national contexts. Finally, recognizing that without effective primary prevention of HIV among women of reproductive age and prevention of unintended pregnancies among women living with HIV, the goal to eliminate new infections in children cannot be achieved, and that effective primary prevention in pregnant women, lowering rates of unintended pregnancies along with limited breastfeeding for women living with HIV would account for 19 per cent of potential reduction in mother-to-child transmission of HIV, UNFPA will support efforts to ensure that human rights, including the reproductive rights of all women and girls – in particular those living with HIV – are protected as a non-negotiable element of all HIV and global health programmes.

58. Notwithstanding the solid commitment within the United Nations system to support national responses to HIV, underlying issues already noted in the present report, especially those related to availability of financial and, more importantly for the United Nations, human resource capacities at all levels, will continue to challenge agency results and national progress towards targets set forth in the political declarations, the UNAIDS strategy and the UBRAF.

## V. Elements for a decision

**59. The Executive Board may wish to take note of the present report and recommend making specific links to the UNAIDS strategy in the respective UNDP and UNFPA HIV strategies and policies, as well as in the respective new UNDP and UNFPA strategic plans to be developed for 2014-2017.**

Annex

# Strategy – At a glance

## Global commitments

**Achieve universal access to HIV prevention, treatment, care and support**

**Halt and reverse the spread of HIV and contribute to the achievement of the Millennium Development Goals**

## Strategic Directions

### Revolutionize HIV prevention

More than 7000 people are newly infected with HIV every day. A revolution in prevention politics, policies and practices is critically needed. This can be achieved by fostering political incentives for commitment and catalysing transformative social movements regarding sexuality, drug use and HIV education for all, led by people living with HIV and affected communities, women and young people. It is also critical to target epidemic hot spots, particularly in megacities, and to ensure equitable access to high-quality, cost-effective HIV prevention programmes that include rapid adoption of scientific breakthroughs.

### Catalyse the next phase of treatment, care and support

A total of 1.8 million people died from AIDS-related causes in 2009. Access to treatment for all who need it can come about through simpler, more affordable and more effective drug regimens and delivery systems. Greater links between antiretroviral therapy services and primary health, maternal and child health, TB and sexual and reproductive health services will further reduce costs and contribute to greater efficiencies. Enhanced capacity for rapid registration will increase access to medicines, as will countries' abilities to make use of TRIPS flexibilities. Nutritional support and social protection services must be strengthened for people living with and affected by HIV, including orphans and vulnerable children, through the use of social and cash transfers and the expansion of social insurance schemes.

### Advance human rights and gender equality for the HIV response

Social and legal environments that fail to protect against stigma and discrimination or to facilitate access to HIV programmes continue to block universal access. Countries must make greater efforts: to realize and protect HIV-related human rights, including the rights of women and girls; to implement protective legal environments for people living with HIV and populations at higher risk of HIV infection; and to ensure HIV coverage for the most underserved and vulnerable communities. People living with and at higher risk of HIV should know their HIV-related rights and be supported to mobilize around them. Much greater investment should be made to address the intersections between HIV vulnerability, gender inequality and violence against women and girls.

## Vision and goals

**Vision: To get to** Zero New Infections

Goals for 2015:

Sexual transmission of HIV reduced by half, including among young people, men who have sex with men and transmission in the context of sex work

Vertical transmission of HIV eliminated and AIDS-related maternal mortality reduced by half

All new HIV infections prevented among people who use drugs

**Vision: To get to** Zero AIDS-related Deaths

Goals for 2015:

Universal access to antiretroviral therapy for people living with HIV who are eligible for treatment

TB deaths among people living with HIV reduced by half

People living with HIV and households affected by HIV are addressed in all national social protection strategies and have access to essential care and support

**Vision: To get to** Zero Discrimination

Goals for 2015:

Countries with punitive laws and practices around HIV transmission, sex work, drug use or homosexuality that block effective responses reduced by half

HIV-related restrictions on entry, stay and residence eliminated in half of the countries that have such restrictions

HIV-specific needs of women and girls are addressed in at least half of all national HIV responses

Zero tolerance for gender-based violence

## Core Themes

**People**

Inclusive responses reach the most vulnerable, communities mobilized, human rights protected

**Countries**

Nationally owned sustainable responses, financing diversified, systems strengthened

**Synergies**

Movements united, services integrated, efficiencies secured across Millennium Development Goals